PEDIATRIC COMMITTEE
OF GOVERNOR'S EMS AND TRAUMA ADVISORY COUNCIL (GETAC)
OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES (DSHS)
MEETING Minutes
May 15, 2013

Call to Order: (Charles Macias, MD, Chair)

1. Roll call and Introduction of new members

   Present: Macias, Brown, Hatstein, Jaquith, Juarez, Lewis, Snow, Walker
   Absent: Brown, Hartstein, Snow

2. Committee liaison reports (will ask to report on August meeting):

a. Air Medical: Jorge Sainz

Update on guidelines for air medical personnel coming into Texas to move patients out of the state. Discussed quality measures. Mutual MOUs also discussed.

b. EMS: Verne Walker: No specific pediatric issues.

c. Education: Charles Jaquith: 5 items on the list for discussion but none related to pediatrics.

d. Injury Prevention: Deb Brown not present. Will report next meeting.

e. Medical Directors: Juan Juarez: Meets this afternoon. No specific pediatric discussions. Mostly in Feb meeting discussed education.

f. Stroke: Julie Lewis: Nothing pertinent to pediatrics. Updates in Feb – CEs specific to stroke possible. CV disease update from Texas Council.

g. Trauma Systems: Verne Walker for Sally Snow: Voted to support position paper for minimizing CT in children as proposed.

h. Regional Advisory Council chairs: Britton Devillier: Not meeting this session.

i. Disaster planning: Charles Jaquith for Bonnie Hartstein: Met in Feb with update in EMTF changing standardization of EMS coordination center. Electromagnetic pulse workgroup.

3. EMS for Children State Partnership update: Sam Vance and Manish Shah

a. Protocol tool. **Evidence based summaries** for pediatric prehospital care. Developed by internal or external groups. Non prescriptive and intended to inform an agencies protocol.

Respiratory distress protocol. Testing currently in Austin, Houston, Dallas.

Protocols through EMSC/NHTSA: Seizure management and Helicopter transport

Evidence based summaries:

Cervical Spine Immobilization: Risk factors for cervical spine injury that can be used to create a selective spinal immobilization protocol?
Non traumatic shock. For hypovolemic shock, rapid delivery of initial fluid boluses (isotonic fluid in aliquots of 20 ml/kg IV or IM) improve quality of care. For profound septic or hypovolemic shock, does fluid bolus alter quality: IO route is recommended if IV route cant be initiated in a timely manner.
Post resuscitation management, how does intubation compare with BVM is preferred to improve outcomes
Therapeutic hypothermia: non neonate (infant or child), is not recommended in the post resuscitation management. For the neonate, there is better evidence, less than one month old., therapeutic hypothermia is recommended
Are the non transports more at risk: decision should be initiated by the parent. Provider should have final decision. For those that refuse transport, are those more at risk for having been abused?. In general not more at risk of abuse unless already suspected.
Does non transport increase risk. Consider online recommendation

How will EMSC state partnership disseminate information? Online through EMSC website coming soon. URL to be sent to stakeholders on the listserve. Endorsed by medical directors subcommittee.

Voted to endorse the tool/website unanimously.

b. Pediatric Readiness Assessment. 60% response rate by hospitals in the state to assess pediatric readiness. State has the largest pediatric population for rural data so very critical to the success of the project nationally. Each domain listed below represents a cluster of activity within the readiness project. A champion was assigned to each domain to report back at the next meeting on best practices strategies. What are some specific examples of how this domain is being addressed in the state? Additionally, what is each members institutions or hospital partners doing to address each domain. All of this will be discussed at the next meeting and an action grid created to help inform the Texas EMSC QI strategy for the readiness project.

Domain	**Description**	**Best Practices**
Administration and Coordination Champion: Deb Brown	Qualifications and responsibilities for the physician coordinator and nursing coordinator staffing the ED	Credentialing, interest, knowledge, skills, and competencies in definitive pediatric care; Promoting and verifying adequate skill and knowledge among ED staff, overseeing QI, periodic review of ED policies and procedures, serving as liaison/coordinator to external staff and relevant contacts Facilitating education, evaluations, and collaboration among physician and nursing coordinators
Physicians, Nursing, and Other Health Care Providers Who Staff the ED	The necessary skills, knowledge, and training in emergency evaluation and treatment of children of all ages	Baseline and periodic competency evaluations for all clinical ED staff

Champion: Charles Jaquith		
QI/PI in the ED Champion: Charles Macias	Pediatric patient care-review process integrated into the QI/PI plan of the ED	EMS spectrum interfacing Pediatric-specific indicators Clinical competency evaluations for credentialing for all licensed ED staff Monitoring professional performance, credentialing, continuing education, and clinical competencies
Improving Pediatric Patient Safety Champion: Julie Brown	Delivery of pediatric care should reflect an awareness of unique pediatric patient safety concerns	Hand off - between providers during shift change; to higher level of care; back to community (committee of quality transformation has hand off guidelines on the way) Safety reporting - non-prescriptive review, root cause analysis strategies Patient identification policies - description of what TJC has on how to use wrist band strategies
Policies, Procedures, and Protocols Champion: Juan Juarez	Policies, procedures, and protocols for the emergency care of children should be developed and implemented, and staff should be educated; should be monitored for compliance and periodically updated	

ED Support Services Champion: Jorge Sainz	Skills, capability, equipment, and safety guidelines for pediatric patients in the radiology department and laboratory	Provide imaging studies and reduce radiation exposure, including referral to appropriate facilities and timely review, interpretation, and reporting of imaging studies Meeting laboratory-based needs of children in the community and referral to appropriate facilities
Equipment, Supplies, and Medications Champion: Sally Snow	Pediatric equipment, supplies, and medications should be appropriate for children of all ages and sizes; easily accessible, clearly labeled, and safely and logically organized	Resuscitation equipment and supplies shall be located in the ED ED staff should be educated, have daily verification of location and function of supplies and equipment Systems should be readily available for proper sizing of equipment and dosing of medications

c. Sam Vance introduced himself as the new program manager for EMSC.
-Next week is EMSC Day
-EMSC reassessment coming soon

4. Update on Child Fatality Review Teams update: Susan Rodriquez
The latest Child Fatality Review Team Annual Report was recently released and it can be found at http://www.dshs.state.tx.us/mch/Child_Fatality_Review.shtm
There is proposed legislation re: making April Water Safety Month in Texas is moving through the legislative process. I will keep you informed as to future hearings on the resolution.

5. Position paper on minimizing radiation: Charles Macias
The group decided that independent work with discussion should ensue. Each subpoint was assigned a champion. The champion will search for best practices and consider which professional societies or organizations we should collaborate or strategize with. Partnerships with radiologic societies, nursing organizations, ER societies or pediatric organizations? Do they have websites? Are there symposia/conferences? Partnership with academic centers or children's hospitals (which ones)? What other strategies to ensure implementation? Each champion should be prepared to discuss their targeted aim listed below.

1. All CT scans on children should be performed using "pediatric" dose-reduction protocols. Pediatric protocols are available through The Alliance for Radiation Safety in Pediatric Imaging. http://www.pedrad.org/associations/5346/ig/
Champion: Verne Walker.

2. Avoidance of the use of protocols which automatically result in the performance of multiple CT studies (i.e. head, cervical spine, chest, and abdomen and pelvis) in pediatric trauma patients.
Champion: Britt Devlier

3. Imaging modalities that do not use ionization radiation, such as ultrasound, should be used when feasible.
Champion: Britt Devillier

4. Understanding and linking guidelines of care that utilize evidence based practice strategies will help minimize the use of unnecessary testing.
Champion: Jorge Sainz

5. Avoidance of further CT imaging once the decision to transfer to definitive care is made, unless the accepting institution specifically requests a scan prior to transfer. If CT imaging is performed prior to transfer, the images should be included in the transfer documentation on disc or some other form of reviewable file. The final radiology report should be forwarded to the receiving facility as soon as possible. Acquisition of radiographic testing, or delaying testing should be balanced against the risk of delaying critical care for stabilization of the ill or injured pediatric patient.
Champion: Juan Juarez

6. Accepting institutions should avoid repeating scans. Consider access to a cloud-based digital image translator.
Champion: Juan Juarez

6. Pediatric transfer guidelines-review Washington State “Pediatric Consultation and

7. Trauma registry. Jorge Sainz. Meets after pedi subcommittee. Will report next meeting.

8. Meeting schedule changes. Group voted for C as first choice then A as second choice.

9.. Future meetings

Next meeting will discuss transfer guides, update Child Fatality, CT minimization project, and Pediatric Readiness project.

Respectfully submitted by Charles Macias